Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
DALLAS NATIONAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-09-B174-01

MFDR Date Received
August 6, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Hospital does not have a negotiated contract with First Health or Carrier. It is impossible to determine how the Carrier denied/reduced charge. . . . Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule."

Amount in Dispute: $5,930.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has made a valid and legal reimbursement denial, or reduction of fees, under the Texas Department of Insurance, Division of Workers' Compensation (DWC) medical fee guidelines, rules and statutes. . . . Additionally, CompIQ reduced the bill based on a PPO discount. Apparently, the Requestor has a contract with a First Health owned PPO. . . . the EOBs attached herewith reflect an appropriate fee reduction pursuant to the State Guidelines as well as the application of the appropriate PPO reductions."

Response Submitted by: Lewis & Backhaus, PC, 14160 Dallas Parkway 400, Dallas, Texas 75254

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2008	Outpatient Hospital Services	$5,930.88	$4,895.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. Texas Labor Code §413.011(d-3) requires that an insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. Information included in a contract under Subsection (d-1) is confidential and is not subject to disclosure under Chapter 552, Government Code. For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review. Notwithstanding Subsection (d-1) or Section 1305.153, Insurance Code, the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: (1) is not provided in a timely manner to the division on the division's request; (2) does not include a specific fee schedule consistent with Subsection (d-1); and (3) does not:(A) clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the named insurance carrier's authorized agent; or (B) comply with the notice requirements under Subsection (d-2).
4. The services in dispute were reduced/denied by the respondent with the following reasons:
   - 97 – Payment is included in the allowance for another service/procedure.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - A First Health/Focus/Aetna Workers Comp Access LLC PPO contract discount was applied. For PPO contract questions, please call (800) 238-6288.
   - 18 – Duplicate claim/service.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted explanations of benefits finds the reduction reason remark "A First Health/Focus/Aetna Workers Comp Access LLC PPO contract discount was applied." The requestor's position statement asserts that "Vista Hospital does not have a negotiated contract with First Health or Carrier." On January 12, 2011, pursuant to 28 Texas Administrative Code §133.307(l), which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request" and Texas Labor Code §413.011(d-3), which states, in pertinent part, that "An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review" the Division requested the respondent to provide a copy of the referenced contract(s) between the parties to the dispute and/or any network as well as documentation to support that the provider was notified in accordance with 28 Texas Administrative Code §133.4. The respondent replied by letter dated January 28, 2011 that "At this time, my client is not in possession of the requested contract. My client and this firm are currently working to obtain a copy of the requested contract. For that reason, we respectfully request you extend our time to provide the requested documentation." As of the date of this review, the respondent has not further responded to the Division request for additional information, nor did the respondent otherwise submit copies of any contract(s) or other additional requested documentation. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no documentation to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g). Review of the submitted documentation finds that, although the requestor did ask for separate reimbursement of implantables, the requestor did not certify the cost of the implantables in accordance with the requirements of §134.403(g)(1), which provides that "A facility or surgical implant provider billing separately for an implantable shall include with

the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.'" The Division finds that the requestor did not meet the requirements of §134.3403(g). Therefore, separate reimbursement of implantables is not recommended and reimbursement shall be calculated as provided in §134.403(f)(1).

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code A4649 is an item or service for which payment is bundled into payment for other physician services on the same date of service.
   - Per CMS correct coding edits, procedure code 76000 is a component service of procedure code 63030 performed on the same date of service. Separate payment is not recommended.
   - Procedure code Q0092 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 63030 is classified under APC 208, which, per OPPS Addendum A, has a payment rate of $2,979.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,787.47. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $1,749.22. The non-labor related portion is 40% of the APC rate or $1,191.65. The sum of the labor and non-labor related amounts is $2,940.87. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as $0.33. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $5,520.00 yields a cost of $1,799.52. The sum of all packaged costs is $1,973.16. This amount added to the service cost yields a total cost of $3,772.68. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. However, the amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is $2,940.87. This amount multiplied by 200% yields a MAR of $5,881.74.
   - Procedure code 99214 has a status indicator of V, which denotes a clinic or emergency department. This service is included in the global surgical package and is not separately reimbursed when performed on the same date as procedure code 63030.
   - Per CMS correct coding edits, procedure code 94762 is a component service of procedure code 94760 performed on the same date of service. Separate payment is not recommended.
   - Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. The total recommended payment for the services in dispute is $5,881.74. This amount less the amount previously paid by the insurance carrier of $986.00 leaves an amount due to the requestor of $4,895.74. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,895.74.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to

additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,895.74, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 15, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.